Affordable Care Act Employer Mandate:

Minimum Essential Coverage (MEC) - Minimum Value – Affordability

The Affordable Care Act (ACA) is a comprehensive healthcare reform law that was first enacted in 2010. A provision of the ACA, known as the Employer Shared Responsibility Payment or Employer Mandate, took effect in 2015. This mandate requires Applicable Large Employers (ALEs), which are employers with 50 or more full-time employees and full-time equivalent employees (FTE), to offer coverage that meets certain criteria or be subject to certain penalties.

The required criteria include offering Minimum Essential Coverage (MEC) to at least 95% of full-time employees and their dependents, excluding spouses, whereby such coverage meets Minimum Value (MV) and is affordable to the employee. To prove compliance with the Employer Mandate, the offers of coverage must be reported through annual filings of forms 1094-B, 1095-B, and 1095-C.

According to the IRS, “An employer-sponsored plan provides minimum value if it covers at least 60 percent of the total allowed cost of benefits that are expected to be incurred under the plan.” Coverage is affordable if the employee’s required contribution for self-only coverage does not exceed a certain percentage of their household income for the taxable year. The IRS has not yet released this percentage for 2025 but it is currently 8.39% for 2024.

How to determine if you are an Applicable Large Employer?

To determine whether an employer is an Applicable Large Employer, take the total number of full-time employees, including full-time equivalents, for each month in the preceding calendar year and divide it by 12. If the number is 50 or greater, then you are an ALE subject to employer shared responsibility provisions.

There are two methods to count employees, with the most common being the monthly measurement method. To use this method, count the number of full-time employees for each calendar month in the preceding calendar year. Full-time employees for this calculation mean those who worked at least 120 hours in each month. Then calculate the full-time equivalents. Add the hours of service for all employees who worked less than an average of 30 hours a week or 120 hours a month in each month. Count no more than 120 hours per employee per month. Then divide the total hours by 120 to get the FTE count for that month. This number is then added to the number of regular full-time employees for each month. Add each month together and divide the total by 12. If that number is 50 or more, the employer is an ALE.

If an employer has a significant number of employees who may fluctuate above and below 30 hours a week, the look-back measurement method provides an alternative method of calculating. Under this method employers test whether an employee averages 30 hours of service for each week during the measurement period to determine full-time or part-time status for that measurement period.

The mandate treats employers in an aggregated group as a single employer for determining ALE status. "Companies with a common owner or that are otherwise related under certain rules of section 414 of the Internal Revenue Code are generally combined and treated as a single employer for determining ALE status."[i] Although employers are aggregated for determining ALE status, potential penalties apply separately to each entity.

What is Minimum Essential Coverage?

There are specific benefits that must be provided under a health plan for it to be considered minimum essential coverage. These benefits fall into the broad categories below.[ii]

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization
- Pregnancy, maternity, and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Birth control coverage
- Breastfeeding coverage

How do you determine if a plan provides Minimum Value coverage?

Health coverage meets minimum value if: 1) the plan pays at least 60% of the total cost of medical services for the standard population, and 2) the plan benefits include substantial coverage of physician services and inpatient hospital services.

The department of Health and Human Services (HHS) developed an actuarial value calculator to help determine if a plan with standard features provides minimum value. The 2025 final actuarial calculator [iii] and methodology [iv] are available for download from CMS.gov. To calculate minimum value, simply enter the requested information about the plan into the calculator, such as its deductibles, coinsurance, copays, and out-of-pockets. If the actuarial value of a plan is at least 60%, then the plan meets minimum value. If a plan has nonstandard features, then an actuarial certification from an actuary is required to show that it meets minimum value standards.

How do you determine if a plan is Affordable?

A plan is affordable if the employee's share of the premium for the lowest-cost self-only coverage does not exceed a certain percentage of their household income (8.39% for 2024). Household income includes all taxable income, such as wages, tips, and bonuses, as well as non-taxable income, such as child support and rental income. Household income is not the same as the employee's salary or wages. Fortunately, since most employers do not know their employee's household incomes, there are three safe harbors for affordable employer-provided coverage under the ACA: 1) W-2 Wages Safe Harbor, 2) Rate of Pay Safe Harbor, and 3) Federal Poverty Level Safe Harbor. An employer that satisfies any one of the three safe harbor provisions has offered employees a plan that is affordable.

W-2 Wages Safe Harbor – Using the W-2 Wages Safe Harbor, the maximum amount an employer will be able to charge for self-only coverage and still be affordable is based on the employee's Box 1 income from their 2024 IRS Form W-2 multiplied by 8.39%. Please note that this method is relatively simple to apply, but it uses current year wages which won't be known until the year is over. That means an employer may not know if coverage is affordable until the year is over.

> *For example, if an employee who has $35,000 in Box 1 of their 2024 W2, the maximum amount an employer can charge monthly for self-only coverage would be $35,000 * 8.39% / 12 = $244.71.*

Rate of Pay Safe Harbor – The Rate of Pay Safe Harbor uses the hourly rate of pay for the employee as it was on the first day of the plan year, unless the rate is reduced, then the reduced hourly rate is used. Since ACA requires coverage to be offered to those working at minimum of 30 hours, the calculation assumes the 30 hours per week as a minimum (or 130 hour per month). The maximum amount the employer can charge for self-only coverage and still be affordable is equal to the lowest hourly pay rate * 130 hours * 8.39%.

> *For example, an employee who earns $20 per hour, the maximum amount an employer can charge monthly for self-only coverage would be $20 * 130 * 8.39% = $218.14.*

Federal Poverty Level Safe Harbor – Under the Federal Poverty Level Safe Harbor, the maximum amount an employer can charge for self-only coverage and still be affordable for plan years that start January through June 2024 is calculated based on the 2023 poverty level and is $101.93 per month for employees working in the contiguous United States, $127.31 in Alaska, and $117.25 in Hawaii. For plan years July through December 2024 those amounts are calculated on the 2024 poverty level and are $105.29 in the contiguous United States, $131.51 in Alaska, and $121.02 in Hawaii.

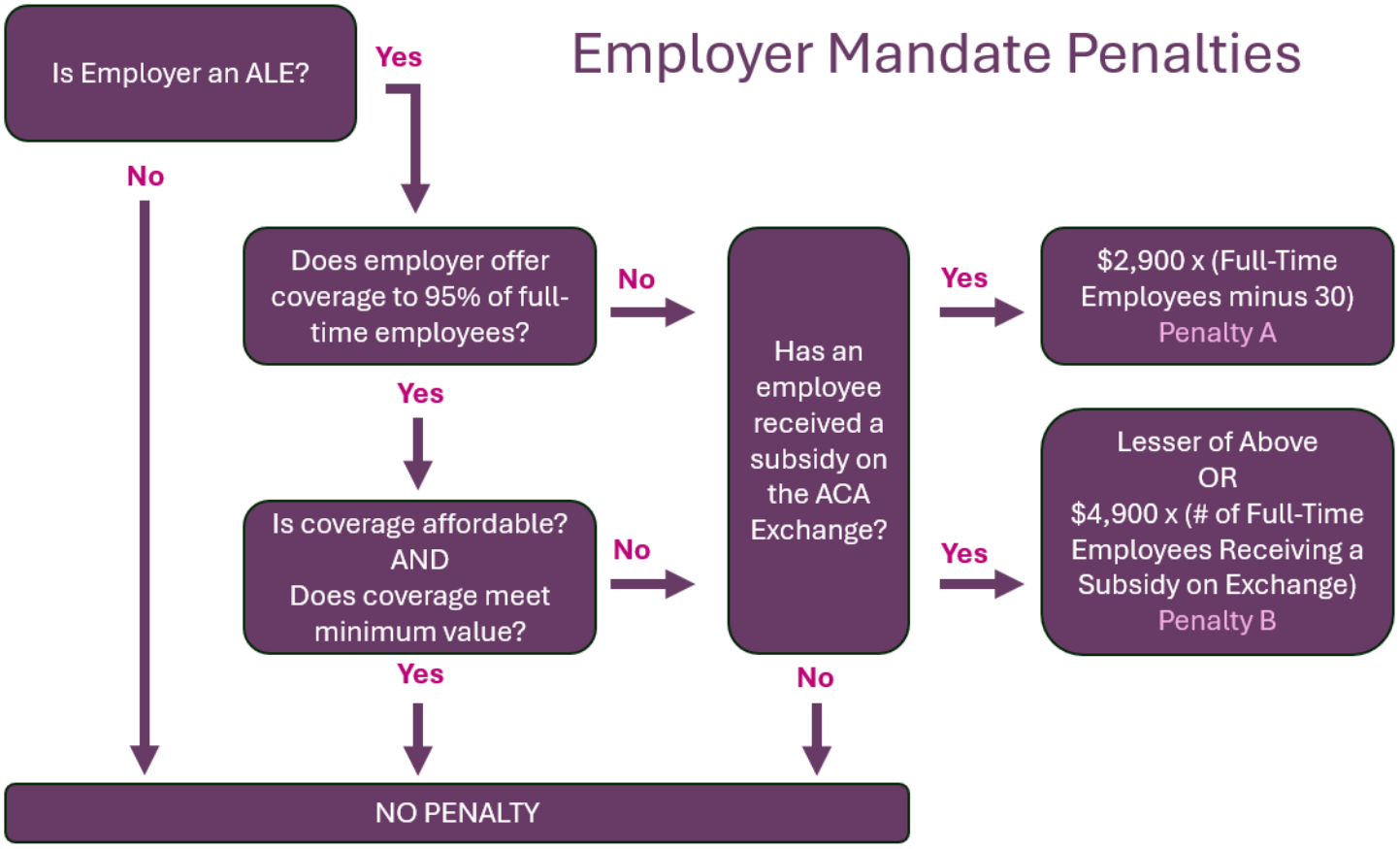
> *For example, the 2024 poverty guideline for a household of 1 in the contiguous United States is $15,060. The maximum amount an employer can charge monthly for self only coverage is $15,060 * 8.39% / 12 = $105.29.*

Employers offering a defined contribution-style flex credit approach for benefit elections should designate a sufficient portion exclusively for health coverage for consideration toward affordability. Contributions are recognized as "a health flex contribution if (1) the employee may not opt to receive the amount as a taxable benefit, (2) the employee may use the amount to pay for minimum essential coverage, and (3) the employee may use the amount exclusively to pay for medical care." [v]

What are the penalties for not meeting the Employer Mandate?

There are two penalties for noncompliance with the Employer Mandate, one for not offering minimum essential coverage, Penalty A, and one for not offering a plan that meets minimum value, Penalty B. The IRS ACA penalty amounts for 2025 for the Penalty A is $2,900 and the Penalty B is $4,350. These amounts are less than the $2,970 and $4,460, respectively, for 2024. Penalties are calculated monthly whereby the monthly penalty is equal to the annual penalty listed above divided by 12.

Employer Mandate Penalties



Penalty A – An employer is subject this penalty if they fail to offer minimum essential coverage to 95% of its full-time employees and their dependents and any full-time employee receives a Premium Tax Credit (PTC) to purchase subsidized coverage through a state or federal Marketplace. The $2,900 annual penalty is per full-time employee, minus the first 30 employees. The penalty applies to each full-time employee, even if they did not receive a premium tax credit and purchase Marketplace coverage.

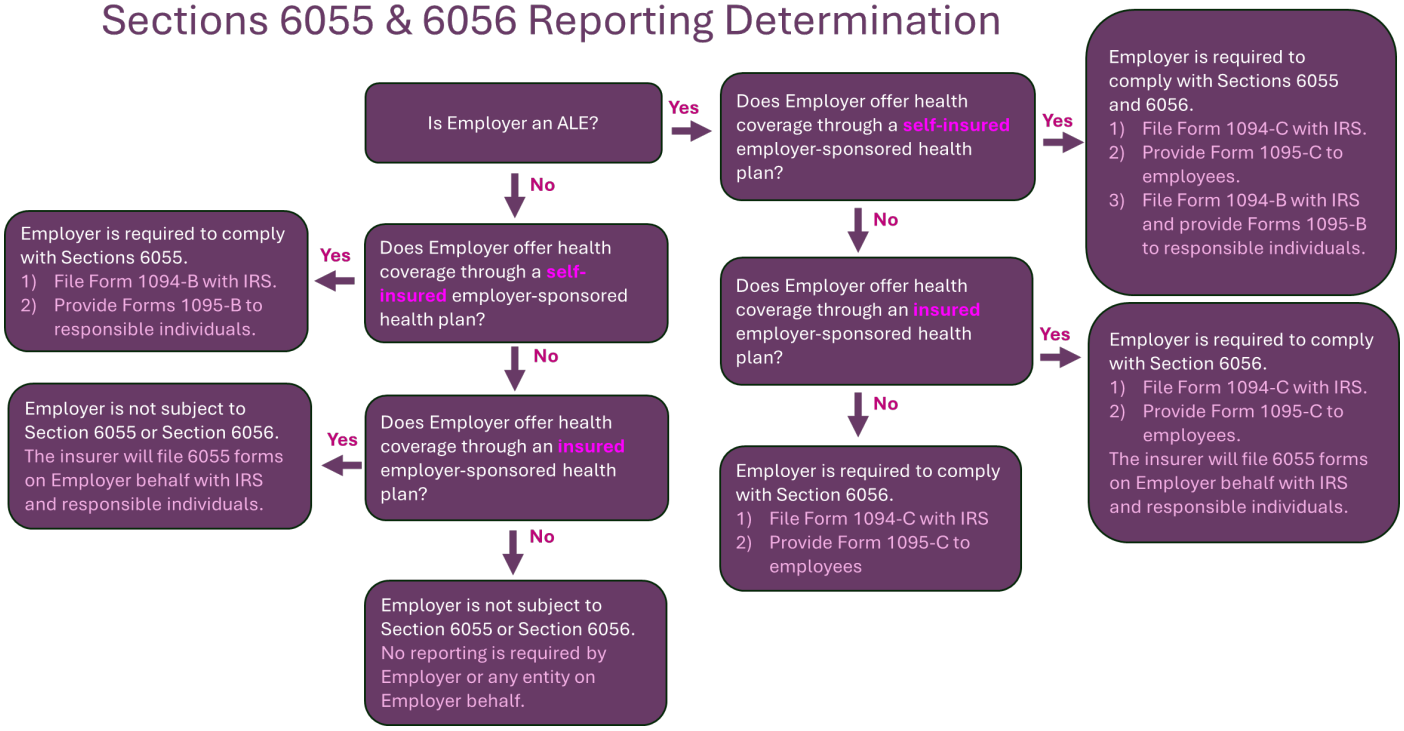
> *For example, if a company has 53 full-time employees and the company does not offer minimum essential coverage and at least one employee purchases Marketplace coverage and receives a subsidy, then the company could be subject to this penalty on all employees minus the first 30. In this example $2,900 * (53 -30) = $66,700 annual penalty. It only takes one employee receiving a PTC to have this penalty apply to all employees.*

Penalty B – An employer is subject to this penalty if they do not offer coverage that is affordable or coverage that meets minimum value and any full-time employee receives a PTC to purchase subsidized coverage through the Marketplace. This $4,900 annual penalty is only applied for each full-time employee that receives a PTC and purchases Marketplace coverage. It also only applies for the months in which those employees were covered and receiving the PTC.

> *For example, this same company, with 53 employees, does not provide coverage that meets the affordability standard and 10 of the companies' employees purchase coverage through the Marketplace. Of these 10 employees only 5 of them receive a PTC and one of the 5 employees only had coverage for 6 months instead of the full year. The penalty calculation would be 4 *$4,900 +1*$4,900*(6/12) = $22,050.*

What are compliance reporting requirements and which employers need to report?

The ACA added two tax code sections 6055 and 6056 which require employers to comply by filing forms 1094-B, 1095-B, and 1095-C.



Section 6055 requires providers of health coverage to report to the IRS and covered individuals that the persons were covered by minimum essential coverage. This demonstrates that each person has satisfied their individual mandate. The federal individual mandate penalty was eliminated in 2019, however, as of 2024, there are still financial penalties imposed by the state for being uninsured in Massachusetts, New Jersey, California, Rhode Island, and the District of Columbia.

Section 6066 "requires employers that are ALEs under the employer shared responsibility provisions to file information returns with the IRS about whether they offered health coverage to their full-time employees (and their dependents) and, if so, information about the offer of coverage. ALEs must also provide a copy of the information to the employee."[vi]

Form 1095-B is used by third-party administrators or insurers and is provided only to covered individuals. It may also be required for large employers offering self-funded coverage to non-employees.

Form 1094-C is a summary of health coverage information ALEs must provide to the IRS and is provided to employees.

Form 1095-C is filed by ALEs that offer fully insured or self-funded coverage under the ACA. All full-time employees must be provided with a 1095-C tax form, even if they do not enroll in offered coverage, and all employees who enroll in self-insured coverage must be provided with a 1095-C tax form, even if they are not full time.

Forms 1094 and 1095 must be filed together as the IRS uses both to determine whether an employer is possibly subject to a penalty under the employer shared responsibility provisions. A penalty applies to employers who fail to comply or fail to properly document their compliance. Employers who fail to file year-end 1095-C and 1094-C forms with the IRS will be penalized a minimum of $570 per eligible employee for the 2024 reporting year. This penalty is like the one for failing to file W-2 forms for employees.

Penalties for not offering the right coverage at affordable levels can add up to a lot of expenses for your business. At Symphony Consulting, we want to help you avoid any potential penalties for lack of proper insurance.

Contact us at Consulting@SymphonyRisk.com for more information regarding your benefit needs.

---

[i] https://www.irs.gov/affordable-care-act/employers/determining-if-an-employer-is-an-applicable-large-employer

[ii] https://www.healthcare.gov/coverage/what-marketplace-plans-cover/

[iii] http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-av-calculator-final.xlsm

[iv] https://www.cms.gov/files/document/draft-2025-avc-methodology-508.pdf

[v] https://www.irs.gov/pub/irs-drop/n-15-87.pdf

[vi] https://www.irs.gov/affordable-care-act/employers/questions-and-answers-on-reporting-of-offers-of-health-insurance-coverage-by-employers-section-6056